SOCIAL NEEDS AND SOCIAL DETERMINANTS OF HEALTH

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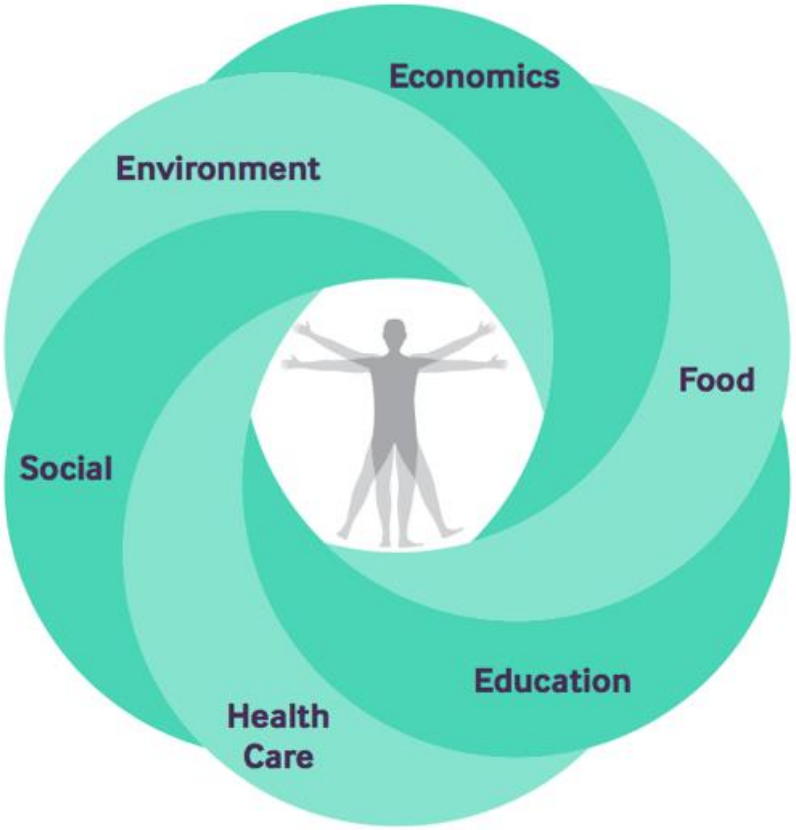
WHAT WE'RE GOING TO TALK ABOUT

- Why social needs?
- What can you do with social needs information?
- ISP Milestones
- What this might look like in real life

SHARED LANGUAGE



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Social Determinants of Health

The conditions in which people are born, grow, work, live, and age

Social Needs

An individual's lack of a resource that is needed to support a healthy lifestyle

SHARED LANGUAGE

Equality vs Equity

Health Equity

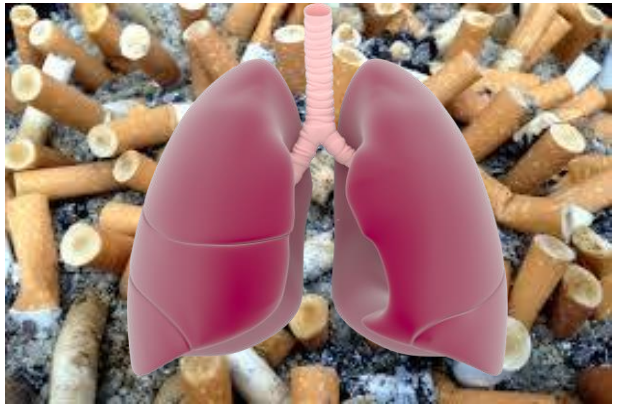
When everyone has a fair and just opportunity to be as healthy as possible

Health Inequity

Avoidable and unfair differences in health rooted in social injustice

WHAT ACTUALLY KILLS PEOPLE?

Heart Attacks
193,000 deaths



Lung Cancer
156,000 deaths

Stroke
168,000 deaths

Galea, 2011

WHAT ACTUALLY KILLS PEOPLE?

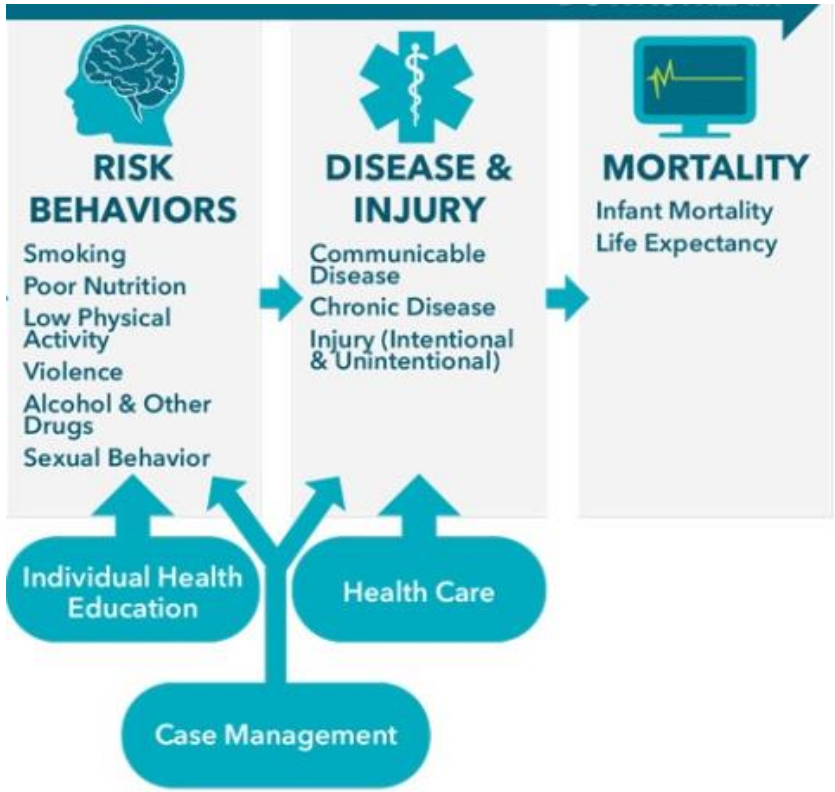
Low Education
245,000 deaths

Low Social Support
162,000 deaths

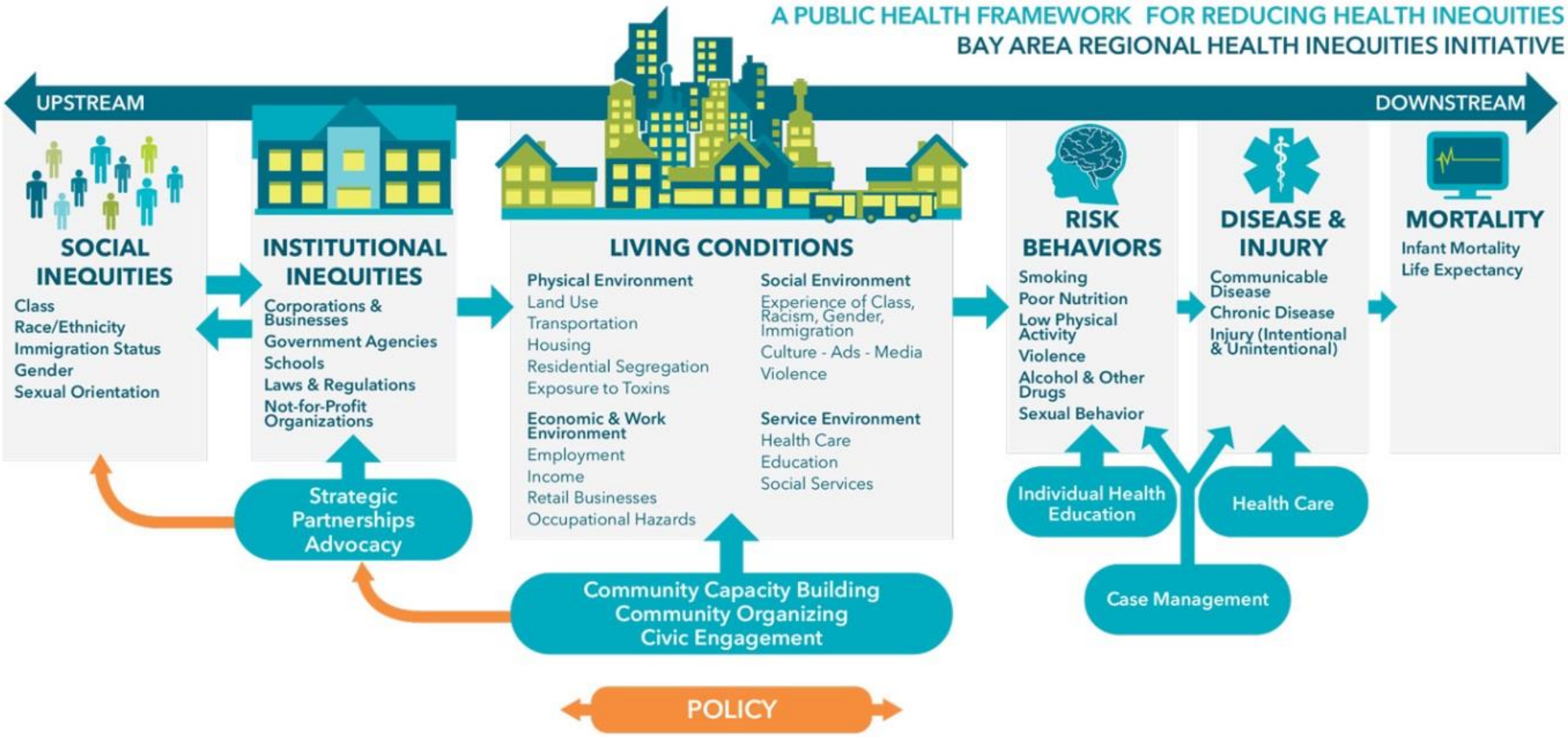
Individual Poverty
133,000 deaths

Galea, 2011

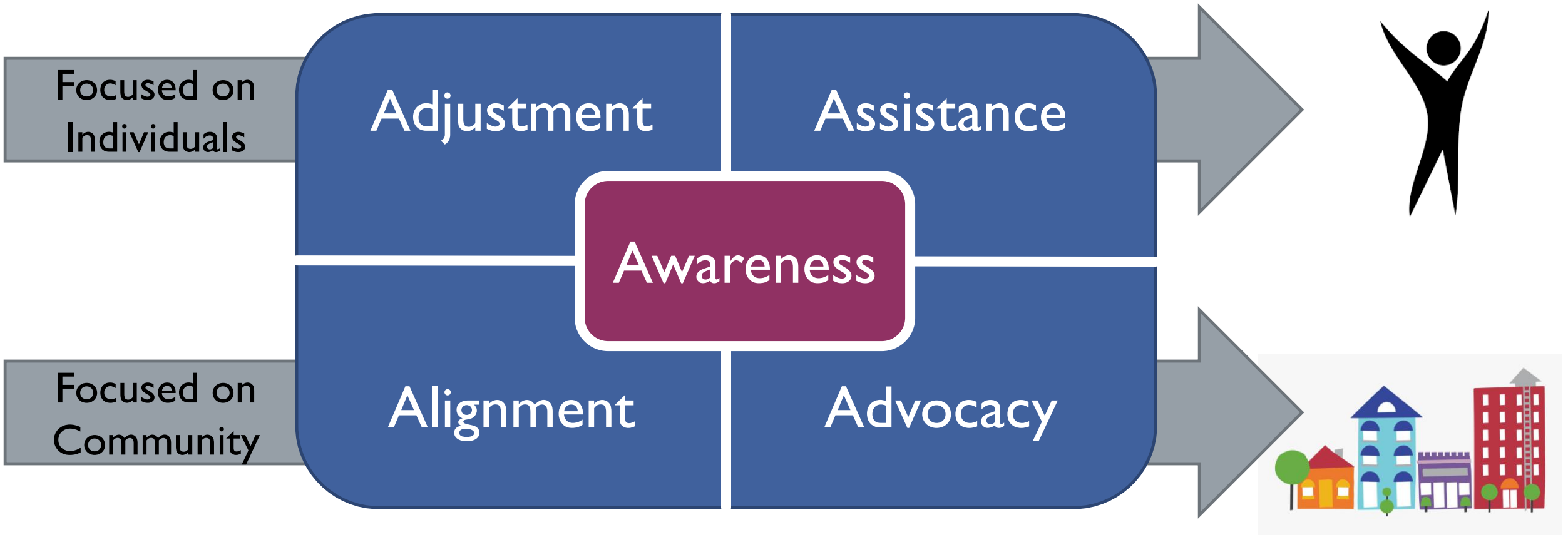
WHERE DOES HEALTHCARE ACT?



WHERE DOES HEALTH ACTUALLY HAPPEN?

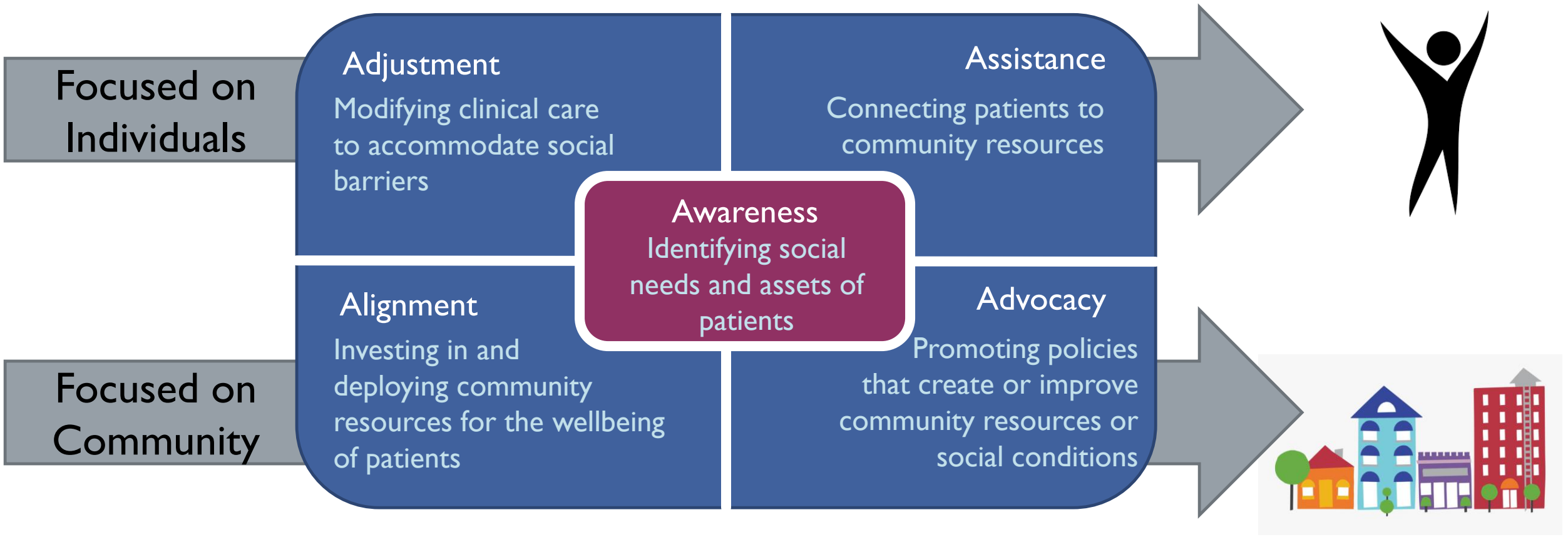


WHAT CAN HEALTHCARE DO ABOUT SOCIAL NEEDS?



National Academies of Medicine, 2019

THAT'S A LOT OF "A" WORDS…



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Transportation Example

Focused on Individuals

Focused on Community

Adjustment
Plan care in a way that minimizes need for transportation

Assistance
Arrange transportation through Medicaid; provide transportation vouchers

Awareness
Ask patients about access to transportation

Alignment
Invest in ride-sharing programs

Advocacy
Promote policies in your community that change transportation infrastructure

National Academies of Medicine, 2019

BUILDING BLOCK: OPTIONAL FOCUS ON ADDRESSING SOCIAL NEEDS OF PATIENTS

Goal: Practice routinely assesses patients for social needs and links them to appropriate community resources.

PRACTICE ROUTINELY ASSESSES PATIENTS FOR SOCIAL NEEDS AND LINKS THEM TO APPROPRIATE COMMUNITY RESOURCES.

Phase 1	Phase 2	Phase 3
Assess social needs of patient population and prioritize one or more to focus on	Develop a process to screen for selected social need and refer to resources	Develop a process to screen for an additional social need and refer to resources
Assess availability of community resources with help of RHC's	Develop community partnerships to help patients with selected social need	Streamline communication between practice and community partners
	Work with RHCs to identify at least one social need that is difficult to address	Work with RHCs to advocate for expanded resources for social need that is difficult to address

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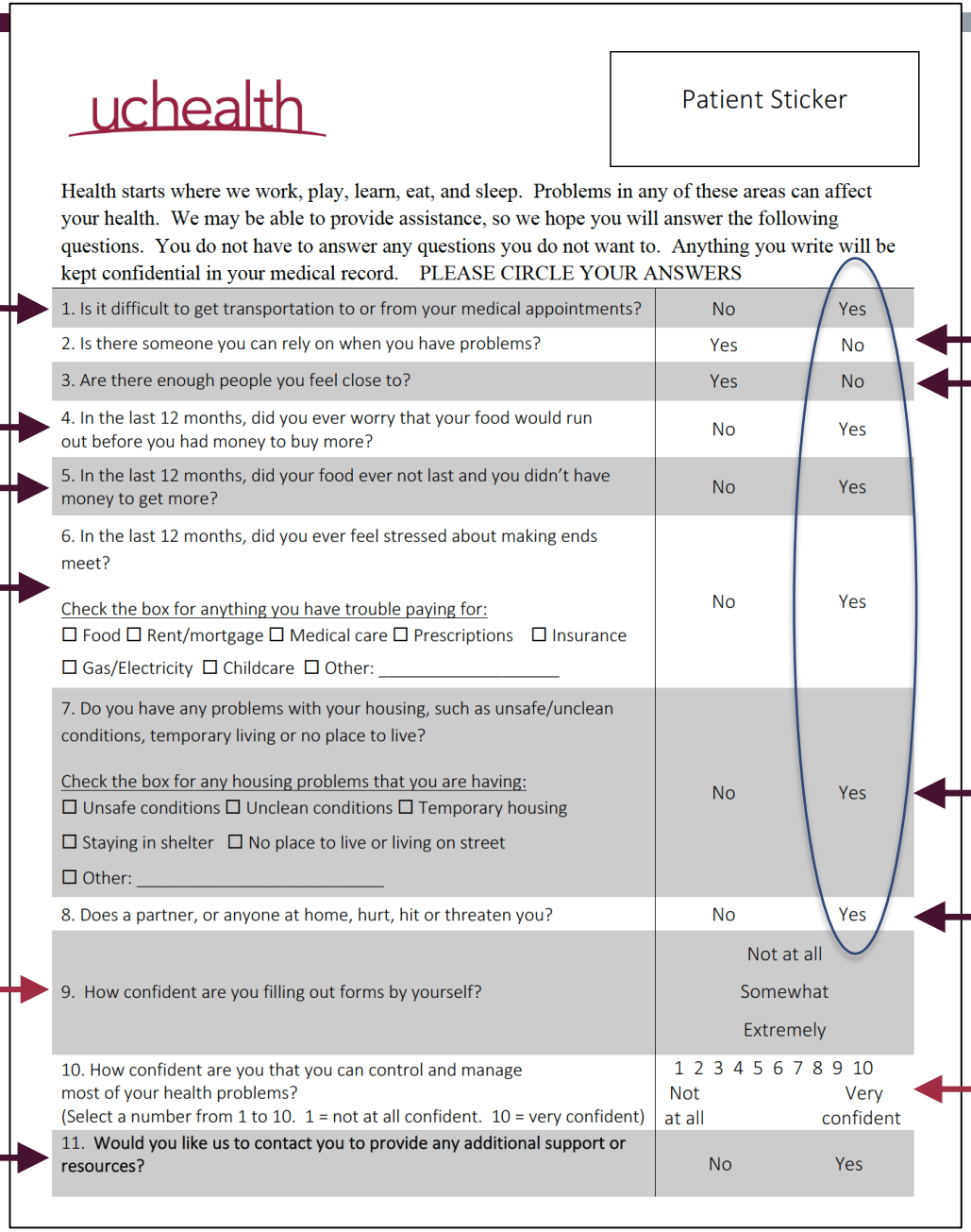
Awareness	Work with RHCs to identify at least one social need that is difficult to address	Work with RHCs to advocate for expanded resources for social need that is difficult to address
Assistance		
Advocacy		

SOCIAL NEEDS SCREENING IN ACTION

- AF Williams Social Needs Screening Pilot
  - November 2017 to July 2018
    - Screened 2018 patients
    - 541 patients with one or more social need
    - 146 patients requested assistance
    - Top needs: Financial strain, social isolation, food insecurity



Transportation

Food Insecurity

Financial Strain

Health Literacy

Request for help

Social Isolation

Housing Problems

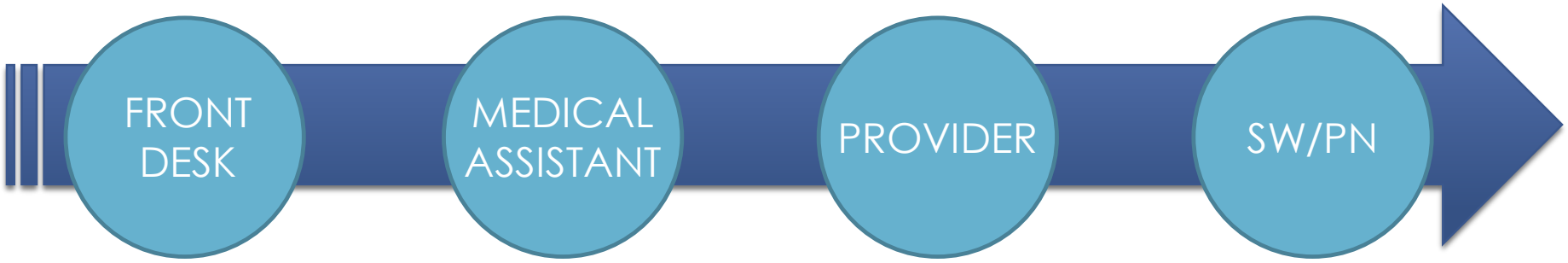
Household Violence

Self-efficacy

SCREENING AND REFERRAL WORKFLOW

✓ Gives paper screener to patient

✓ Discusses screening results with patient
✓ Signs social work order



✓ Collects screener
✓ Enters results into EMR
✓ Pends social work order (if indicated)
✓ Hands off results to provider +/- SW

✓ Refers patients to community resources (In person or via phone)

New adult and pediatric visits, annual exams, well child checks

COMMUNITY PARTNERSHIPS

HUNGER FREE COLORADO

- Electronic referral system
- SNAP enrollment
- Monthly data reports

- Client intake completed by our staff
- Extended hours

AICS
AURORA INTERFAITH COMMUNITY SERVICES

COLORADO
REGIONAL HEALTH CONNECTORS

- Connections to community service providers

OUR KEY TAKEAWAYS

- Staff and provider champions are essential to success
- Culture building improves buy-in
- Asking about social needs feels intrusive but most patients appreciate the attention to whole-person wellbeing
- Don’t reinvent the wheel

WHY YOU GUYS ARE PERFECT FOR THIS WORK

Regional Health Connectors

Knowledge of community assets and challenges

Community perspective

Facilitation of clinic-community relationships

Identifying opportunities for advocacy

Practice Facilitators

Ability to promote culture and cultivate champions

Big-picture thinking

Attention to detail

Ensure that all perspectives are heard

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